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OVERVIEW

Payment is made after you submit a valid claim for payment for services provided. You do not need to know if a client is Medicaid-eligible or eligible for other specific funding streams. You do not have to bill third-party payers before submitting a claim for payment.

Once a billing, or invoice, for a service is submitted to the Department, any contractor's clinical and fiscal records related to that service are subject to a billing audit.

BILLING PROCEDURES

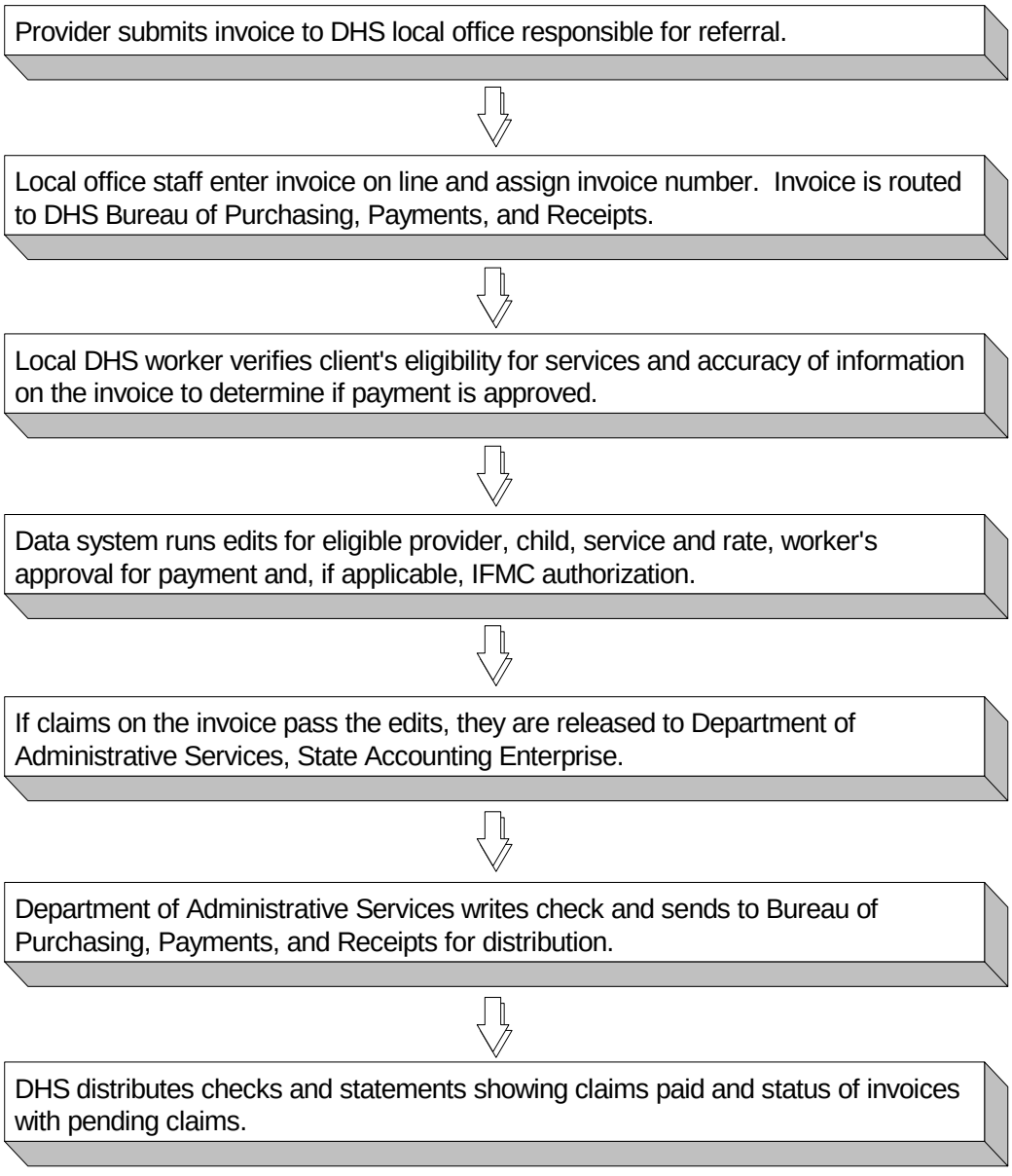
You may have two contracts with the Department: one for rehabilitative treatment and supportive services and one for purchase of social services. Although the same invoice form is used to bill under both contracts, you must complete a separate invoice for each contract (agreement) number.

The rehabilitative treatment and supportive services contract number will always begin with 29, e.g., 29-75-051. The contract (agreement) number for a provider of social services, e.g., independent living, adult residential services, etc., will begin with "30."

The instructions that follow apply only to billing for rehabilitative treatment and supportive services. If you have a Purchase of Social Services contract, complete invoices for that contract in accordance with the procedures set forth in the ***Purchase of Service Provider Handbook***.

Note: Billings for services C6 and C7, foster family initial and annual home studies, are done according to purchase of social service procedures, because they are not directed at a specific child. Consult your project manager if you need help with the procedure for these billings.

Billing and Payment



Unit of Service and Unit Rates

Legal reference: 441 IAC 185.106(4) Unit of Service and Unit Rates

Consider all members of a family collectively to be one recipient of any unit of non-residential service. Consider service to the family or to one or more of its members as one unit of service.

Base service billings for family-centered rehabilitative treatment and supportive services on one-half hour of direct face-to-face contact between you and the family or one or more of its members. Round monthly cumulative units up or down to the nearest whole unit. Exceptions:

- The unit of service for family team meeting facilitation is facilitation of one meeting.
- The unit of service for relative home study is the completed study.
- The unit of service for a relative home study update is the completed update.

When cotherapy is provided, bill at the rate per unit of group therapy service for one therapist unless the group consists of two or more families and four or more children.

The cotherapy payment rate is determined by dividing the reasonable and necessary cost for the service by the average number of unrelated persons in attendance in the group. Only the following services may have a cotherapy rate determined:

- Family-centered services, therapy and counseling
- Family foster care, therapy and counseling
- Additional group care, therapy and counseling for children
- Optional group care, therapy and counseling for families

The rate for cotherapy shall be no more than 150 percent of the rate for group therapy and counseling services using one therapist. When you do not have a rate established for group therapy and counseling services using one therapist, the ceiling will be 150 percent of the median rate for group therapy and counseling services using one therapist, as determined by the Department.

Purchase of Service Provider Invoice, Form 470-0020

Legal reference: 441 IAC 185.121(234) Billing Procedures

Submit claims for rehabilitative treatment and supportive services on form 470-0020, *Purchase of Service Provider Invoice.* You may use a computer-generated version of this form with prior approval from the Department's Bureau of Purchasing, Payments, and Receipts.

Normally the billing period is from the first day of the month through the last day of the month. At the end of each month, prepare form 470-0020 for the rehabilitative treatment and supportive services provided during the month.

Never bill for service in more than one month on an invoice. Submit a separate invoice for each separate month of service, even if the service span overlaps one month. Submit invoices for family preservation services at the end of the month in which services are terminated.

Submit a separate invoice for each program. For example, one invoice can be used to bill for A1-10 and A3-50. A second invoice must be completed for C1-10, etc. Also prepare separate invoices for each county from which clients are referred. Example:

> John, Mary, and Ron are all referred to Provider A from Woodbury County. John and Mary both receive family-centered therapy and counseling and family-centered skill development. Ron is receiving family foster care therapy and counseling.
>
> Provider A submits one invoice for services provided to John and Mary and a second invoice for services provided to Ron.
>
> If Mary were from Mills County instead of Woodbury, Provider A would have to submit three invoices: one for John, one for Mary, and one for Ron.

Send complete invoices to the Department office responsible for the client for approval. If the information on the invoice is not accurate and complete, claims may be rejected.

Iowa Department Of Human Services

Page _____ of _____

PURCHASE OF SERVICES PROVIDER INVOICE

DHS use only

Invoice No. _____

Agreement No. _____

Provider Name _____
(Please print or type)

Billing Period _____ State/Local _____

Provider Addr _____

County No. and Name _____
(Please print or type)

City/State _____ Zip _____

	Case Number	Client's Name Last	First	M.	Service Date Beginning	Ending	Service Code	Unit Cost	No. of Units	Total Cost	Fees	Credits	Net Cost
01													
02													
03													
04													
05													
06													
07													
08													
09													
10													
11													
12													
							TOTALS						

I certify that the items for which payment is claimed were provided and are unpaid.

Claimant_____ Date_____

Approval_____ Date_____

470-0020 (Rev. 2/02) White: Central Office Yellow: County Pink: Provider

Instructions for Completing the Invoice

Complete the page numbers in the upper right corner of the invoice.

Enter all dates in six digits as month, day, and year (example: 12-20-94 or 12/20/94). Dollar amounts must always include the decimal point followed by two digits. (Example: $12.50, $5.00).

Invoice Number. Leave this space blank. This number is assigned by the Family and Childrens Services (FACS) data processing system when the county office enters the invoice.

Billing Period. Enter the first and last dates of the billing period (usually the first and last day of the month). For family preservation services, this is the month in which service was terminated.

State/Local. Leave blank, except for services C6 and C7, foster family initial and annual home studies. For these services, enter "H," even when services are provided in a decategorization county.

County Number and Name. Enter the number and name of the county with financial responsibility.

Agreement Number. Enter the seven-digit contract number from your *Rehabilitative Treatment and Supportive Services Contract*, form 470-3052.

Provider Name. Enter your name as it appears on the Purchase of Service Rate List. The name on the rate list is how the name is entered onto the purchase of service payment system. The system accepts up to 24 characters. It is essential that the name entered on the invoice match the name entered on the payment system to avoid rejected claims.

Provider Address. Enter the mailing address to which the warrant is to be mailed. This address must match the mailing address specified on your contract.

Case Number. Enter the state identification number assigned to the service billing client in the Family and Children's Service (FACS) system. This number is provided on form 470-3055, *Referral of Client for Rehabilitative Treatment and Supportive Services*.

Client's Name. Enter the service billing client's last name, first name, and middle name or initial from the *Referral of Client for Rehabilitative Treatment and Supportive Services*. The name must match the name as entered on the FACS system. The system accepts up to 16 characters for the surname and 10 characters for each of the first and middle names.

Service Beginning Date. For services other than family preservation, when billing for the first month of services, enter the date that services began. When billing for months after the first month, leave blank.

For family preservation services, if the service begins and ends in the same month, enter the date the service began. If the service begins in one month and ends in another, leave the beginning date blank. (**Note:** There is only one billing for family preservation services. Submit the invoice after services are terminated.)

Service Ending Date. Enter the service ending date only for clients who are terminating the service in the month covered by this claim. Enter the service ending date on the last billing only.

For family preservation and foster family home studies, the termination date is the date on which the service was completed. When a service, including family preservation, begins and ends in the same month, enter both a beginning date and an ending date.

Service Code. The service code you enter must coincide with the service code in the contract and with the service code on the *Referral of Client for Rehabilitative Treatment and Supportive Services*. Submit a separate invoice for each program. (All the codes on the invoice must begin with the same letter.) For group care, remember to bill for both the service and maintenance codes.

Unit Cost. Enter the cost for one unit of service as approved by the Department.

Number of Units. Enter the number of whole units provided to each client during the billing month. The Department's data system will not accept partial units.

For family preservation, family team meeting facilitation, relative home studies and updates, and foster family home studies, the number of units billed will always be one.

For group care maintenance and service where the unit is a day, enter the actual number of calendar days in the month for clients who received service each day in the month. See **Billing for Group Care** for more information on defining whether a child is present or absent, partial months of service, and reserve bed days.

For other services where the unit of service is a half hour, once each month, total the amount of the billable time for each client and round to the nearest whole unit.

Total Cost. Enter the product of the unit cost and the number of units.

Fee. Leave blank.

Credits. Leave blank.

Net Cost. Leave blank.

Totals. When all services have been entered, accumulate and enter totals by column for all pages on the last page. Totals are required for units, fees, credits and net amount. Do not total the unit cost column.

Claimant. Your signature and the date of your signature are needed on the last page only. The invoice must have an original signature. No rubber-stamped or photocopied signatures are allowed.

When you need multiple pages for one invoice, complete the 12 service lines of the form before starting on another page. On following pages, enter the contract (agreement) number and page, and then continue with the service lines. You need not repeat the remaining heading data.

Keep the pink copy and forward the remaining ones to the Department office purchasing the service. If you use a computer-generated form, submit the original and one copy to that office and keep a third copy for your records.

Payment made from copies of originals is subject to state audit exception.

Billing for Group Care

Do not bill group care per diem service or maintenance units on any given day in excess of your facility's licensed capacity. Bill for the actual days of service if:

- A child was present and
- You have documentation that service was provided every day.

For example, bill for 28 (or 29) days in February for a child who was present and received service every day in February. Also, bill for 31 days in March for a child who was present and received service every day.

When a child is placed in group care for a partial month, bill for service and maintenance for the actual number of days the child was in placement. In computing the number of days of service when a child is admitted after the first day of the month, count the day the child enters the facility. Do not count the day that the child leaves if it is before the end of the month.

Presence in a Facility

For **maintenance** payment, a child is considered present in the facility if the child is in the facility for any portion of the day, defined as 24-hour period between midnight and midnight. Conversely, a child is considered *absent* from the facility if the child is gone from the facility for the entire day.

A maintenance payment can be made when a child is absent from the facility for family visits, hospitalization, runaway, or preplacement visit if the absence meets all other requirements for reserve bed payment.

For **service** payment, a child is considered present in the facility if the child is in the facility for at least a portion of the day, and the facility has provided and documented provision of rehabilitative treatment services to the child that day.

Service payment cannot be made for any day a child is considered absent from the facility. A child is considered absent from the facility for service if:

- The child is gone from the facility for the entire day, or
- The child is absent from the facility a portion of the day and the facility has not provided rehabilitative treatment to the child that day, or
- The child is present in the facility during the day, but there is no documentation of service provision.

Example:

John has a home visit from Friday to Sunday. The facility prepares John for the home visit Thursday evening, as John's caseworker is picking him up at 7:00 a.m. Friday morning. John receives no rehabilitative treatment Friday. John returns to the facility Sunday afternoon, and the facility staff provide rehabilitative treatment Sunday evening by working with him to process what happened during the visit.

Maintenance: In this example, John is considered absent from the facility Saturday only. The provider can bill for Saturday, however, as a reserve bed day, assuming all other reserve bed policy requirements are met.

Service: In this example, John is considered absent from the facility both Friday and Saturday. The provider cannot bill for either Friday or Saturday.

The following table explains when to bill a daily unit of service and maintenance and a half-hour unit of optional and additional services for group care. A "day" is defined as 12:00 a.m. (midnight) to midnight.

Situation	**Per Diem Service** D16x D26x D36x D46x	**Additional Service** D5	**Optional Service** D6 D7	**Per Diem Maintenance** D19x D29x D39x D49x
Child is present in the facility during the day (other than school) and you have documented service provision.	Bill	Bill	Bill	Bill
Child is absent from the facility during some portion of the day (other than school) and you have documented service provision.	Bill	Bill	Bill	Bill
Child is absent from the facility during some portion of the day (other than school) and there is no documentation of service provision.	Do not bill	Do not bill	Do not bill	Bill
Child is absent from the facility for a full day.	Do not bill	Do not bill	Bill, if service is documented	Bill, if the absence meets the requirements for a reserved bed day (See **Billing for Reserve Bed Days**.)
The child is present in the facility during the day and there is no documentation of service provision.	Do not bill	Do not bill	Do not bill	Bill
Day of discharge.	Do not bill	Do not bill		Do not bill

Billing for Reserve Bed Days

The Department may provide payment for group care maintenance for family visits, hospitalization, runaways, and preplacement visits. Payment for reserve bed days is made for the maintenance portion of the program only.

The Department pays for reserve bed days only when the intent of the Department and the facility is for the child to return to the facility after the absence. If you refuse to accept the child back, you must return the reserve bed payments.

You must document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the child's quarterly report. Family visits and preplacement visits to another foster care placement or an adoptive placement must be consistent with the child's case permanency plan. Your staff must be available to provide support to the child and family during visits or hospitalization.

You must notify the worker of each family visit and its planned length before the visit. Contact the worker at least 48 hours in advance of planned hospitalization and within 24 hours after an unplanned hospitalization or after the child runs away.

Payment is canceled the day after:

- You and the Department agree that the return would not be in the child's best interest, or
- The court (or the parent, in a voluntary placement) decides not to return the child to your facility.

Following is a summary of the limits to reserve bed payments:

NUMBER OF RESERVE BED DAYS IN GROUP CARE FACILITIES

Reason	Worker Approval	Service Area Manager Approval
Family Visits	Up to 14 consecutive days	Up to 30 consecutive days
Hospitalization	Up to 14 consecutive days	Up to 30 consecutive days
Runaway	Up to 14 consecutive days	Up to 30 consecutive days
Preplacement Visit	Up to 2 consecutive days	N/A

Time Limit for Submitting Invoices

The time limit for submission of the original claim is 90 days from the date of service. **Exception:** At the end of the state fiscal year, claims for services through June 30 are to be submitted by August 10.

All claims for the fiscal year ending June 30 must be paid within 60 days from the end of the fiscal year. Claims not paid by that time must be submitted to the State Appeal Board.

Invoices that remain unpaid 60 days after June 30 (the end of the state fiscal year) are returned to the provider unpaid. If the claim is not submitted within the required time, you may file the unpaid claim against the state by using form 532-1247, *State Appeal Board Claim Form and Affidavit*.

Instructions for completing form 532-1247are included on page two of the form. The form must be notarized. Instructions for submission of the form are given on the front of the form. The form can be obtained on the Internet at: http://www.dom.state.ia.us/appeals/forms/abclaim.pdf

PAYMENT

Within 60 days of the date of receipt of a valid invoice, the Department will make payment in full of all invoices for rehabilitative treatment and supportive services provided to eligible clients. Invoices are subject to audit and adjustment by the Department.

In general, if an invoice is received by Central Office in the morning mail on Tuesday, and the Department service worker has approved the claims, the check will be mailed to the provider on Friday afternoon. This schedule may vary if there is a holiday.

The Department may pay interest on a claim that remains unpaid after 60 days of receipt of a complete and accurate claim in accordance with policies and procedures established by the Department of Administrative Services in the Pre-Audit Manual, Procedure 230.250.

Resubmittals of Rejected Claims

When valid claims originally submitted within the time specified above are rejected because of an error, resubmit them as soon as you can make corrections. Be aware, however, of the time limits for payment at the end of the fiscal year. If a rejected claim is not paid within 60 days of the end of the fiscal year, you must submit the claim to the State Appeal Board as described previously.

Payment Reductions or Across-the-Board Cuts

Legal reference: 441 IAC 152.2(26) Across-the-Board Cuts

Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31. In the event that across-the-board cuts result in reduced payments, no contract amendment will be required. Rates will be reduced by the amount required to meet the requirements of the budget reduction, and the Chief of the Bureau of Purchased Services or designee will notify providers in writing by of the method and amount of reduction.

BILLING REPORTS

Provider Statement

You will receive a computer-generated report, *Provider Statement*, S472N013, which lists the claims paid in each check. This is the document you use to track payment of your claims. These reports are run weekly and are normally delivered to the Department's Bureau of Purchasing, Payments, and Receipts each Friday. The Bureau mails the report to you.

Data on the report are organized as follows:

- **Provider.** Your RTSS provider number.
- **Warrant.** The unique identifying number on the check.
- **Provider Name and Address.** The address where the check is mailed.
- **Issue Date.** The date that the check is printed. Usually, they are mailed on the next working day.

- **Amount.** The total amount of the payment included in this check.
- **Invoice Number.** The number of the invoice that contains this claim. Claims from more than one invoice can be paid with the same warrant.
- **Line Item.** The line number from this claim on the original invoice.
- **State ID.** This client's state identification number (the entry from the "Case Number" column of the invoice).
- **Name.** The name of the client for whom the claim was made.
- **Worker County.** The number of the county where the Department worker carrying the child's case is housed.
- **Service Code.**
- **Claim Month.** The month in which the claimed service was delivered.
- **Unit Rate.**
- **Amount.** The amount paid on this claim.

```
REPORT:  S472N013-02        IOWA DEPARTMENT OF HUMAN SERVICES              PAGE        1
                              FAMILIES AND CHILDREN SERVICES          12/03/2005  02.12.35
                                     PROVIDER STATEMENT

      PROVIDER:  1234567 000                                          WARRANT:  000000000

        [Provider name and address]                                ISSUE DATE:    12/02/2005
                                                                       AMOUNT:       $000.00

INVOICE     LINE                                    WRK   SERV    CLAIM          UNIT
NUMBER      ITEM   STATE ID   NAME                  CTY   CODE    MONTH    UNITS RATE     AMOUNT
123456789   0001   0000000Z   DOE  JANE              77    A000    12/2005   00   00.00     000.00
```

Provider Invoice Status Report

The *Provider Invoice Status Report*, S472N087-1, is a computer-generated report that lists the status of all of a provider's outstanding claims. This report is issued weekly on Friday, and is delivered to the Department's Bureau of Purchasing, Payments, and Receipts each Monday. The Bureau forwards a copy of the report both to providers and to Department local office staff.

Data on the report is organized as follows:

- **Invoice Number.** The invoice number is generated by the FACS system when staff in the Department's local office first enter the invoice into the system. Invoices are listed in order of entry, with the oldest first.
- **Item.** This is the line number from the original invoice. All the claims from the invoice continue to show on the report until each of the claims is paid.
- **Client Name.**
- **State ID.** This is the entry from the "Case Number" column of the invoice.
- **Service Month.**
- **Service Code.**
- **County.** This is the number of the county where the Department worker carrying the child's case is housed.
- **Worker Name.** This is the name of the Department worker carrying the child's case.
- **Status.** The five possible status entries for the payment on each claim are listed and defined on the first page of the report. (See the report sample on the next page.) "Unapproved" means that the Department worker carrying the child's case has not yet made entries on the FACS system to approve payment of the claim.
- **Status Date.** This is the date that the present claim status was achieved.
- **Amount.**
- **Warrant Number.** For payments that have been issued, the report lists the number of the warrant (check) that included the payment amount. This corresponds to the warrant number on the *Provider Statement*.

REPORT: S472N087-1

IOWA DEPARTMENT OF HUMAN SERVICES
FAMILIES AND CHILDREN SERVICES
PROVIDER INVOICE STATUS REPORT

DATE OF RUN: 03/03/06
TIME OF RUN: 20:59:10
PAGE NUMBER: 1

PROVIDER NUMBER: 0000000
PROVIDER LOCATION: 000
PROVIDER NAME:
PROVIDER ADDR:

ENTERED = UNAPPROVED PAYMENT
APPROVE = AWAITING ISSUANCE
PENDING = AWAITING WARRANT #
ISSUED = ISSUED PAYMENT
REJECT = REJECTED/CANCELLED
999999 = APPEAL BOARD MEMBER

OUTDATE=INVOICE OVER 60/90 DAYS

INVOICE NUMBER	ITEM	CLIENT NAME	STATE ID	SERVICE MONTH	CODE	COUNTY	WORKER NAME	STATUS	STATUS DATE	AMOUNT	WARRANT NUMBER
123456789	001	DOE, JOHN	0000000Z	12/2005	A000	77	JONES, JANE	ISSUED	02/01/2006	$ 000.00	000000000
	002	SMITH, JANE	0000001Z	12/2005	A000	77	JONES, JANE	ENTERED	02/08/2006	$ 000.00	000000000
234567891	001	DOE, JOHN	0000000Z	02/2006	A000	77	JONES, JANE	APPROVE	03/01/2006	$ 000.00	000000000
	002	DOE, JOHN	0000000Z	02/2006	A000	77	JONES, JANE	APPROVE	03/01/2006	$ 000.00	000000000

FAMILY ASSISTANCE AND OTHER PAYMENTS

Separate payment processes exist for goods and services outside the definitions of rehabilitative treatment and supportive services. These include payments from the Family Assistance Fund and payments for certain services for children in foster care.

When family preservation treatment services have been authorized, the family assistance fund allows you to purchase goods or services for families when the purchase meets the following requirements:

- The purchase helps remove barriers to or is otherwise necessary to the achievement of child placement prevention goals.
- Funds for the goods or services purchased are not otherwise available from local, state, federal, or other sources in a timely manner.
- The purchase occurs during the period of time the family is receiving family preservation treatment services.
- The purchase is for emergency food, shelter, clothing or other time-limited emergency assistance that is directly related to the goal of reducing the risk of placement.

Family assistance funds cannot be used for goods or services you have agreed to provide directly, to provide a reward or incentive related to service engagement or service plan follow-through, or for any other purpose except as specified above.

Determine the amount of family assistance funds used for each family, if any, and purchase goods or service for eligible families when the purchase meets the requirements listed above; the amount of a single purchase or the sum of multiple purchases for a family during the course of treatment services is less than $200.

Obtain written approval from the service area manager or designee before using family assistance funds when you determine that a single purchase of $200 or more is warranted or that multiple purchases for a family during the course of family preservation treatment services totaling $200 or more are warranted.

The service area manager may require written approval before you make subsequent family assistance fund purchases or may notify you to discontinue family assistance fund services.

Iowa Department of Human Services

FAMILY ASSISTANCE FUND REPORT

1. Client Name:_____

2. Agency:_____ 3. DHS Region_____

4. List expenditures and attach original receipt.

Date Purchased	Describe Item or Service*	Amount Paid

* List payee name and address if not identified on receipt. TOTAL $_____

5. Briefly explain how the purchase reduced the risk of placement.

FP Worker's Signature:_____ Date:_____

Supervisor's Review & Verification:_____ Date:_____

DHS Approval if over $200:_____ Date:_____

6. Explain why other resources were not used. Identify resources considered and partial contributions, if any.

Family Assistance Fund Report, Form 470-2412

Complete the *Family Assistance Fund Report*, form 470-2412, for all purchases. Submit form 470-2412 and the original receipt to the Department along with an original signed form GAX, *General Accounting Expenditure*, to obtain reimbursement from the Family Assistance Fund.

Reimbursement of the actual purchase price of documented and allowable purchases is the only cost that can be reimbursed through the Family Assistance Fund. The cost of staff time and travel to work with the family when purchasing items is considered part of the cost of delivering family preservation services.

Obtain approval before the purchase if expenditures exceed $200 for one item or $200 for multiple items for the same family. Otherwise, the Department will review and approve purchases upon submission of form 470-2412 for payment.

Obtain the name, address, phone number, and original signature of the vendor for each purchase. Attach original receipts listing:

- The items purchased.
- Date of purchase.
- Amount of purchase.

Document the placement prevention impact of the purchase, your attempts to obtain other funding for the resource, and the Department's approval when approval is required. For each item or service listed in Item 4, explain in Item 5 how the purchase reduced the risk of placement and what service goals were achieved because of the purchase.

Your worker's signature indicates information entered on the form is accurate and assures that the purchase was necessary to reduce the risk of placement.

Your supervisor's signature indicates that the supervisor has reviewed the intent and use of the purchase and verifies that the purchase was necessary to achieve placement prevention goals.

The signature of the Department staff indicates that the Department approves the purchase as appropriate use of family assistance funds and in keeping with the intent and language of the contract or service agreement.

Submit the original report to the service area manager or designee within 20 days after the month of purchase in a packet containing the following items.

- The original form 470-2412 for each purchase during the month.
- Original receipts for each purchase.
- Original form GAX requesting reimbursement for all purchases during the month.
- Two photocopies of the original packet described above.

Keep the yellow copy of form 470-2412.

General Accounting Expenditure, Form GAX

The *General Accounting Expenditure* is used to authorize payment for a variety of expenses. These instructions pertain only to providers claiming reimbursement for:

- Family Assistance fund payments in the Family Preservation Program, or
- Other expenses paid in the foster care program, such as:
  - Birth certificates.
  - Life books.
  - Medical expenses that cannot be covered by the Medicaid program, including transportation in some situations.

The Department worker or designated clerical staff prepare the form when expenses are incurred that require issuance of a special warrant. Four copies are essential. Local procedures may require a copy for the claimant or a control copy for the service area file.

The person or agency making the claim must sign the form and may be asked to complete the following items:

- **Description:** Enter an itemized list of expenses being claimed.
- **Unit Price:** Show the total price for each item.
- **Claimant's Certification:** The claim must be signed by the person to whom the warrant will be issued (a representative of the agency).

Send the original GAX with original signatures along with original receipts or verification and two copies of the whole packet to the service area manager for approval and then:

- For Family Assistance Fund expenditures, send the material to the family-centered service program manager in the Division of Behavioral, Developmental, and Protective Services for Families, Adults, and Children.
- For other expenses, send the material to the adoption program manager in the Division of Behavioral, Developmental, and Protective Services for Families, Adults, and Children. For medical expenses, also send a memo explaining what the charges are and why they cannot be billed to Medicaid.

Attach supporting documentation
to the back of this form

STATE OF IOWA

GAX

BUDGET FY	**GENERAL ACCOUNTING EXPENDITURE**		DOCUMENT NUMBER
	DATE	ACCTG PERIOD (MM/YY)	

VENDOR CODE	AGENCY NAME Department of Human Services

VENDOR NAME AND ADDRESS	BILL TO ADDRESS (ORDERING AGENCY) Department of Human Services	SHIP TO ADDRESS

TERMS	FOB	ORDER APPROVED BY	GOODS RECEIVED/SERVICES PERFORMED DATE INITIALS
QUANTITY	VENDOR'S INVOICE DATE	VENDOR'S INVOICE NUMBER	

ORDERED	RECEIVED	UNIT OF MEASURE	DESCRIPTION	UNIT PRICE	TOTAL PRICE
	YES NO		Contract Number: Reference Number:		
EFT IND	☐ ☐		Paid Date:		
			DOCUMENT TOTAL		

CLAIMANT'S CERTIFICATION

I CERTIFY THAT THE ITEMS FOR WHICH PAYMENT IS CLAIMED WERE FURNISHED FOR STATE BUSINESS UNDER THE AUTHORITY OF THE LAW AND THAT THE CHARGES ARE REASONABLE, PROPER, AND CORRECT, AND NO PART OF THIS CLAIM HAS BEEN PAID.

DATE **TITLE**

CLAIMANT'S SIGNATURE

AGENCY CERTIFICATION

I CERTIFY THAT THE ABOVE EXPENSES WERE INCURRED AND THE AMOUNTS ARE CORRECT AND SHOULD BE PAID FROM THE FUNDS APPROPRIATED BY:

CODE OR CHAPTER SECTION(S)

AUTHORIZED SIGNATURE

THE FOLLOWING FIELDS ARE FOR STATE ACCOUNTING USE ONLY

LINE	FUND	AGCY	ORGN	SUB ORGN	ACTV	RSRC	SUB RSRC	FUNC	OBJT	SUB OBJT	JOB NUMBER	REP CAT	QUANTITY / UNITS	I / D	DESCRIPTION	AMOUNT	I / D	P / F
01																		
02																		
03																		
04																		
05																		
06																		
07																		
08																		
09																		
10																		
11																		
12																		
13																		
14																		

DOCUMENT TOTAL

GAX (Rev. 2/05) WARRANT # AUDITED BY PAID DATE

Iowa Department of Human Services

For Human Services use only:

General Letter No. 15-C-AP-23
Employees' Manual, Title 15
Chapter C Appendix

March 10, 2006

REHABILITATIVE TREATMENT AND SUPPORTIVE SERVICES
MANUAL TRANSMITTAL NO. 06-1

ISSUED BY: Division of Behavioral, Developmental, and Protective Services
Division of Fiscal Management

SUBJECT: Employees' Manual, Title 15, Chapter C, Appendix, ***Rehabilitative Treatment and Supportive Services Provider Handbook***:

Table of Contents, pages 1 and 2, revised;

Chapter A, *Introduction*, Table of Contents, page i, revised; pages 4, 5, and 6, revised; and page 7, new;

Chapter B, *Description of Service*, Table of Contents, page i, revised; pages 1, 2, and 4 through 17, revised; and pages 18 through 23, new;

Chapter C, *Provider Certification or Approval*, Table of Contents, pages i and ii, revised; pages 1, 3 through 8, 16 through 21, 23, and 27 through 33, revised; and page 34, new;

Chapter D, *Contract*, Table of Contents, page i, revised; pages 5 through 12, 13 through 42, 103, 104, 105, 109, 115, 123, 124, 127, 128, and 131, revised; and pages 12a and 42a through 42i, new;

Chapter F, *Service Authorization and Documentation*, Table of Contents, page i, revised; pages 1, 2, 5, 6, 15, 16, 20, and 21, revised; and pages 16ab, 16b, and 22 through 41, new;

Chapter G, *Billing and Payment*, Table of Contents, page i, revised; and pages 1 through 23, revised;

Chapter H, *Audits, Sanctions, and Appeals*, Contents, page i, revised; pages 1 through 9, revised; and pages 10 through 35, new.

Summary

This General Letter incorporates changes to the service requirements for family-centered supervision services and the available family-centered supportive service components. Effective May 1, 2005, family-centered services administrative rules became effective to facilitate implementation of the Department's child welfare redesign initiative. These amendments made the following changes to family-centered services:

- For family-centered supervision, a maximum billing limit of 60 minutes per calendar month of services is established for indirect behavioral monitoring contacts by telephone to either:
  - Respond to a family crisis or
  - Monitor a child's whereabouts and adjustment.

  The Department worker must specifically approve provision of indirect behavioral monitoring contacts on form 470-3055, *Referral of Client for Rehabilitative Treatment and Supportive Services*.
- For family-centered supervision provider staff qualifications, college coursework in the fields of either education or child development can now be used to substitute for up to two years of the required prior work experience, in addition to the college coursework in the social or behavioral sciences already allowed. Thirty semester hours of such education is considered equivalent to one year of work experience.
- The following new supportive service components are added:
  - Community resource procurement services
  - Family team meeting facilitation
  - Flexible family support fund
  - Parental counseling and education services
  - Relative home studies and home study updates

This letter also incorporates information about records review in RTSS billing audits. As an RTSS contractor, you are expected to have a quality control process that enables you to produce and maintain the required documentation with a consistently high degree of reliability.

The qualified individual who provided the service at close to the same time as the service was delivered should create all of the documentation required to substantiate your billings to the Department. <u>This documentation must be placed in the client's individual treatment record before you bill for that service</u>. Do <u>not</u> bill for a service for which you do <u>not</u> have documentation of the provision of that service in the client's individual treatment record that adequately supports that billing.

Once a billing has been submitted, do not alter, change, or remove this documentation from the client's individual treatment record. After you have submitted a billing for a service, you may only supplement the documentation placed in each client's individual treatment record in accordance with the procedures for curing documentation deficiencies specified in the new section, **Documentation Deficiency Cures**, in Chap-ter H.

Other changes to the Handbook:

- Reflect its availability electronically.
- Clarify terminology about rehabilitative service needs.
- Clarify requirements for staff qualifications.
- Add information about contracts with limited liability companies

Effective Date

Family-centered supervision changes were effective March 1, 2005.
New family-centered supportive services took effect May 1, 2005.
Changes in family-centered supportive service fixed rates took effect July 1, 2005.

Material Superseded

Remove from Employees' Manual, Title 15, Chapter C, Appendix, ***Rehabilitative Treatment and Supportive Services Provider Handbook***, and destroy:

Page	Date
Table of Contents (page 1)	January 1, 2004
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2e	April 1, 2002
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3	October 1, 2001
4	September 1, 1994
5	August 1, 1995
6-9	September 1, 1994

Additional Information

Please contact your Department project manager or service area manager with any questions.

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

To access this manual, choose the links to “Policy Manuals,” then “Social Services,” then “Contracts.” Then select “15-C-RTSS Provider Manual” and under this heading, the chapter or appendix you want to view. You will need Adobe Reader software to view these documents. A link to download the software free of charge is available on the web site. Additional instructions on how to use the web site are available in the “help” section.

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

DHS Bureau of Purchased Services
1305 E. Walnut St.
Des Moines, IA 50319-0114

Include your provider number, name, address, and the transmittal number that you are requesting.

If you have any certification questions, please contact the TA/QA certification staff person assigned to you from Iowa State University. If you have contracting or billing questions, please contact your project manager.